

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
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NAME OF PROVIDER OR SUPPLIER: AVENTURA AT PEMBROOKE STATE LICENSE NUMBER: 230602	STREET ADDRESS, CITY, STATE, ZIP CODE: 1130 WEST CHESTER PIKE WESTTOWN, PA 19382
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
E 0039 SS=E		E 0039		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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E 0039 SS=E	Continued from page 1 483.73(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:	E 0039	The facility lacked documentation verifying a full-scale exercise had been conducted in the last twelve months. No residents were affected. All residents have the potential to be affected. A full-scale exercise will be completed within 30 days by the Emergency preparedness plan committee as required. The facility will reach out to the healthcare coalition and will participate in a full scale exercise if available. Director of Maintenance and maintenance staff were educated by the Administrator on the requirement. The Maintenance Director/Designee will conduct a semi annual audit on an ongoing basis to ensure compliance with conducting a full-scale exercise has been conducted as required. Results of audits will be reviewed at the Quarterly Quality Assurance and Improvement Committee Meeting over the duration of the audit process. Based on the results of the	Completion Date: 09/12/2025 Status: APPROVED Date: 08/15/2025

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E 0039 SS=E	Continued from page 2 (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite	E 0039	audits, a decision will be made regarding the need for continued submission and reporting.	

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E 0039 SS=E	Continued from page 3 the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or	E 0039		

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E 0039 SS=E	Continued from page 4 (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based	E 0039		

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E 0039 SS=E	Continued from page 5 or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may	E 0039		

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E 0039 SS=E	Continued from page 6 include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.	E 0039		

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E 0039 SS=E	Continued from page 7 (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.	E 0039		

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E 0039 SS=E	Continued from page 8 (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.	E 0039		

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E 0039 SS=E	Continued from page 9 (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise	E 0039		

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E 0039 SS=E	Continued from page 10 following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by:	E 0039		

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E 0039 SS=E	Continued from page 11 Based on document review and interview, it was determined the facility failed to maintain the Emergency Preparedness Program. Findings include: 1. Review of documentation and interview on August 5, 2025, between 8:35 AM and 10:45 AM, revealed the facility lacked documentation verifying a full-scale exercise had been conducted in the last twelve months. Interview at the time of the exit conference with the Administrator, Regional Director, Regional Maintenance Director and the Environmental Services Director on August 5, 2025, at 1:00 PM, confirmed the facility lacked full scale exercise documentation.	E 0039		



Certified End Page

AVENTURA AT PEMBROOKE

STATE LICENSE NUMBER: 230602

SURVEY EXIT DATE: 08/05/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on August 5, 2025, it was determined that Aventura at Pembroke was not in compliance with the requirements of 42 CFR 483.73.	E 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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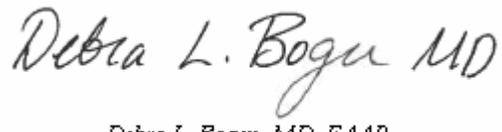
AVENTURA AT PEMBROOKE

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I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

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K 0000	INITIAL COMMENT Facility ID #230602 Component 02 South Building Based on a Medicare/Medicaid Recertification Survey completed on August 5, 2025, it was determined that Aventura at Pembroke was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a four-story, Type II (000), unprotected noncombustible structure, without a basement, which is fully sprinklered.	K 0000		
K 0161 SS=C		K 0161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: AVENTURA AT PEMBROOKE STATE LICENSE NUMBER: 230602		STREET ADDRESS, CITY, STATE, ZIP CODE: 1130 WEST CHESTER PIKE WESTTOWN, PA 19382		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0161 SS=C	Continued from page 1 NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small	K 0161	Facility is requesting DOH complete an FSES for us, center will submit life safety drawings that were requested	Completion Date: 09/12/2025 Status: APPROVED Date: 08/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: AVENTURA AT PEMBROOKE STATE LICENSE NUMBER: 230602		STREET ADDRESS, CITY, STATE, ZIP CODE: 1130 WEST CHESTER PIKE WESTTOWN, PA 19382		
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K 0161 SS=C	Continued from page 2 floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on document review and interview, it was determined the facility failed to maintain building construction requirements, throughout the component. Findings include: 1. Observation and review of documentation on August 5, 2025, between 8:15 AM and 1:00 PM, revealed this is a four-story, Type II (000), unprotected noncombustible structure, which is fully sprinklered. This type of construction is not permitted under the 2012 Edition of the Life Safety Code to be more than two-stories for an existing sprinklered health care occupancy. Interview at the time of the exit conference with the Administrator, Regional Director, Regional Maintenance Director and the Environmental Services Director on August 5, 2025, at 1:00 PM, confirmed the facility has too many stories for the construction type.	K 0161		
K 0293 SS=E		K 0293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
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NAME OF PROVIDER OR SUPPLIER: AVENTURA AT PEMBROOKE STATE LICENSE NUMBER: 230602	STREET ADDRESS, CITY, STATE, ZIP CODE: 1130 WEST CHESTER PIKE WESTTOWN, PA 19382
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K 0293 SS=E	Continued from page 3 NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:	K 0293	The facility failed to maintain exit signs to be continuously illuminated, on one of four floors. No residents were identified. All residents have the potential to be affected. The exit sign, above the door leading to grade from the stair tower near the Elevator Lobby, was repaired to ensure it is continuously illuminated as required. Facility wide audit was completed by the Maintenance Director to ensure that there are no other open areas in walls. The Maintenance Director was educated on the requirement by the Administrator. The Maintenance Director/Designee will conduct compliance audits to ensure that exit signs meet the requirement. The audits will be weekly for four weeks, then monthly ongoing thereafter. The administrator will conduct quarterly random audits thereafter to spot check. The results of the audits	Completion Date: 09/12/2025 Status: APPROVED Date: 08/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
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K 0293 SS=E	Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain exit signs to be continuously illuminated, on one of four floors within the component. Findings include: 1. Observation on August 5, 2025, at 11:43 AM, revealed the exit sign, above the door leading to grade from the stairtower near the Elevator Lobby, was not illuminated. Interview at the time of the exit conference with the Administrator, Regional Director, Regional Maintenance Director and the Environmental Services Director on August 5, 2025, at 1:00 PM, confirmed the exit sign lacked illumination.	K 0293	will be discussed monthly and quarterly by the Quality Assurance and Performance Improvement Committee for the duration of the audit process (3 months). Based on the results of these audits a decision will be made regarding the need for continued submissions and reporting	
K 0345 SS=E		K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
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K 0345 SS=E	Continued from page 5 NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	The facility failed to maintain the fire alarm system, for seven of seven smoke compartments. No residents were affected by this deficient practice. All residents have the potential to be affected. On 8/12/2025, the Maintenance Director was educated by the Administrator on the requirement that a semi-annual visual inspection of the fire alarm system is required. A semi-annual visual inspection of the fire alarm system was completed. Fire alarm system was audited to ensure compliance with the requirement. The Maintenance Director/Designee will conduct compliance audits semi-annually on ongoing basis to ensure that a semi-annual visual inspection of the fire alarm system is completed. Results of audits will be reviewed at Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a	Completion Date: 09/12/2025 Status: APPROVED Date: 08/14/2025

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K 0345 SS=E	Continued from page 6 Based on document review and interview, it was determined the facility failed to maintain the fire alarm system, for seven of seven smoke compartments within the component. Findings include: 1. Review of documentation and interview on August 5, 2025, between 8:35 AM and 10:45 AM, revealed the facility could not produce documentation of a semi-annual visual inspection of the fire alarm system. Interview at the time of the exit conference with the Administrator, Regional Director, Regional Maintenance Director and the Environmental Services Director on August 5, 2025, at 1:00 PM, confirmed the facility lacked the documentation at the time of the survey.	K 0345	decision will be made regarding the need for continued submission and reporting.	
K 0353 SS=E		K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: AVENTURA AT PEMBROOKE STATE LICENSE NUMBER: 230602		STREET ADDRESS, CITY, STATE, ZIP CODE: 1130 WEST CHESTER PIKE WESTTOWN, PA 19382		
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K 0353 SS=E	Continued from page 7 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	The facility failed to maintain the sprinkler system, on three of four floors. No residents were affected. All residents have the potential to be affected. The open area in the wall behind the A bed in room 315 on the 3rd floor was repaired. The open area in the wall behind the B bed in room 204 on the 2nd floor was repaired. The sprinkler over the B bed in room 102 on the 1st floor was repaired and paint was removed. Facility wide audit was completed to ensure that there are no other open areas in walls. An audit of the facility's remaining sprinklers was completed by the Director of Maintenance to assure that they meet the requirement. Director of Maintenance and maintenance staff were educated by the Administrator on the requirement to maintain the sprinkler system according to the regulation. Director of Maintenance and maintenance staff were educated by	Completion Date: 09/12/2025 Status: APPROVED Date: 08/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
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K 0353 SS=E	Continued from page 8	K 0353	<p>the Administrator on sprinkler head inspection to ensure that they meet the requirement.</p> <p>The Maintenance Director/Designee will conduct one random weekly audit to ensure that there are no open areas in walls for four weeks, then monthly for two months and quarterly thereafter.</p> <p>The Maintenance Director/Designee will conduct one random weekly audit of all sprinklers for four weeks, then monthly for two months and then quarterly thereafter.</p> <p>Results of audits will be reviewed at the Quarterly Quality Assurance and Improvement Committee Meeting over the duration of the audit process. Based on the results of the audits, a decision will be made regarding the need for continued submission and reporting.</p>	

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K 0353 SS=E	Continued from page 9 Based on observation and interview, it was determined the facility failed to maintain the sprinkler system, on three of four floors within the component. Findings include: 1. Observation on August 5, 2025, between 11:13 AM and 11:33 AM, revealed the following conditions, which could cause a delay in sprinkler activation: a. 11:13 AM, 3rd floor Room 315, an approximately 12 inch by 2 inch wide open area in the wall, behind the A-bed; b. 11:33 AM, 2nd floor Room 204, an approximately 12 inch by 2 inch wide open area in the wall, behind the B-bed. Interview at the time of the exit conference with the Administrator, Regional Director, Regional Maintenance Director and the Environmental Services Director on August 5, 2025, at 1:00 PM, confirmed the open areas in the resident room walls. 2. Observation on August 5, 2025, at 12:06 PM, revealed the sprinkler over the B-bed in Room 102, on the 1st floor, was covered in what appeared to be paint overspray. Interview at the time of the exit conference with the Administrator, Regional Director, Regional Maintenance Director and the Environmental Services Director on August 5, 2025, at 1:00 PM, confirmed the sprinkler was covered with an unauthorized coating of paint.	K 0353		

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K 0363 SS=E		K 0363		
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K 0363 SS=E	Continued from page 11 NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 0363	The facility failed to maintain corridor doors, on three of four floors. No residents were affected. All residents have the potential to be affected. The corridor door on the 3rd floor, Room 315 was repaired to meet the regulation and latch in the corresponding frame. The corridor door on the 2nd floor, room 220 was repaired to ensure smoke tight integrity. The 2nd floor, the hole noted in the clean utility door, near the nurses' station was repaired. The corridor door on the 1st floor, room 128 was repaired to ensure smoke tight integrity. The corridor door on the 1st floor, room 107 was repaired to ensure smoke tight integrity. An audit of the facility's remaining resident corridor doors was completed by the Director of Maintenance to ensure that all doors meet the requirement. Director of Maintenance and maintenance staff were educated by	Completion Date: 09/12/2025 Status: APPROVED Date: 08/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
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K 0363 SS=E	Continued from page 12 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 0363	the Administrator on maintaining corridor doors to meet the requirement of smoke tight integrity and latch properly. The Maintenance Director/Designee will conduct one weekly audit of corridor doors to check function and integrity for four weeks. The audits will continue monthly thereafter. Results of audits will be reviewed at the Quarterly Quality Assurance and Improvement Committee Meeting over the duration of the audit process. Based on the results of the audits, a decision will be made regarding the need for continued submission and reporting.	

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K 0363 SS=E	Continued from page 13 Based on observation and interview, it was determined the facility failed to maintain corridor doors, on three of four floors within the component. Findings include: 1. Observation on August 5, 2025, between 11:09 AM and 12:00 PM, revealed the following corridor door deficiencies: a. 11:09 AM, 3rd floor, Room 315 failed to latch in the corresponding frame; b. 11:19 AM, 2nd floor, Room 220 lacked smoke tight integrity, while latched in the frame; c. 11:27 AM, 2nd floor, the Clean Utility door, near the Nurses' Station, had an open hole where the lockset was removed; d. 11:55 AM, 1st floor, Room 128 lacked smoke tight integrity, while latched in the frame; e. 12:00 PM, 1st floor, Room 107 lacked smoke tight integrity, while latched in the frame. Interview at the time of the exit conference with the Administrator, Regional Director, Regional Maintenance Director and the Environmental Services Director on August 5, 2025, at 1:00 PM, confirmed the corridor door deficiencies.	K 0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
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K 0374 SS=E		K 0374		
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NAME OF PROVIDER OR SUPPLIER: AVENTURA AT PEMBROOKE STATE LICENSE NUMBER: 230602		STREET ADDRESS, CITY, STATE, ZIP CODE: 1130 WEST CHESTER PIKE WESTTOWN, PA 19382		
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K 0374 SS=E	Continued from page 15 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	The facility failed to maintain smoke barrier doors to be smoke tight, on one of four floors. No residents were affected. All residents have the potential to be affected. The smoke barrier doors, near the Laundry Area on the ground floor, were repaired to close smoke-tight, when released from the hold-open devices. An audit of the facility's remaining smoke barrier doors was completed by the Director of Maintenance to ensure that all smoke barrier doors were smoke-tight when released from the hold-open devices and closed. Director of Maintenance and maintenance staff were educated by the Administrator on the requirement. The Maintenance Director/Designee will conduct one weekly audit of smoke barrier doors for four weeks, then monthly for two months and then quarterly thereafter. Results of audits will be reviewed at the Quarterly Quality Assurance and Improvement Committee Meeting	Completion Date: 09/12/2025 Status: APPROVED Date: 08/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: AVENTURA AT PEMBROOKE STATE LICENSE NUMBER: 230602		STREET ADDRESS, CITY, STATE, ZIP CODE: 1130 WEST CHESTER PIKE WESTTOWN, PA 19382		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0374 SS=E	Continued from page 16 Based on observation and interview, it was determined the facility failed to maintain smoke barrier doors to be smoke tight, on one of four floors within the component. Findings include: 1. Observation on August 5, 2025, at 12:20 PM, revealed the smoke barrier doors, near the Laundry Area on the ground floor, failed to close smoke-tight, when released from the hold-open devices. Interview at the time of the exit conference with the Administrator, Regional Director, Regional Maintenance Director and the Environmental Services Director on August 5, 2025, at 1:00 PM, confirmed the smoke barrier doors failed to fully close.	K 0374	over the duration of the audit process. Based on the results of the audits, a decision will be made regarding the need for continued submission and reporting.	
K 0521 SS=E		K 0521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: AVENTURA AT PEMBROOKE STATE LICENSE NUMBER: 230602		STREET ADDRESS, CITY, STATE, ZIP CODE: 1130 WEST CHESTER PIKE WESTTOWN, PA 19382		
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K 0521 SS=E	Continued from page 17 NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 0521	The facility failed to maintain air conditioning systems, on one of four floors. No residents were affected. All residents have the potential to be affected. The portable air conditioning unit, located in large common area near the Nurses' Station, was removed so it is not vented directly into the interstitial space of the ceiling. The expected date for HVAC to be repaired is September 30th 2025 with the portable air conditioners removed before 10/31/2025. An audit was completed by the Maintenance Director to ensure that no portable air conditioning units were vented directory into the interstitial space of the ceiling with no concerns and found to be in compliance. Director of Maintenance and maintenance staff were educated by the Administrator on the requirement. The Maintenance Director/Designee will conduct one weekly audit of the portable air conditioner for four	Completion Date: 09/12/2025 Status: APPROVED Date: 08/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: AVENTURA AT PEMBROOKE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1130 WEST CHESTER PIKE WESTTOWN, PA 19382		
STATE LICENSE NUMBER: 230602				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0521 SS=E	Continued from page 18 Based on observation and interview, it was determined the facility failed to maintain air conditioning systems, on one of four floors within the component. Findings include: 1. Observation on August 5, 2025, revealed a portable air conditioning unit, located in large common area near the Nurses' Station, was vented directly into the interstitial space of the ceiling. Interview at the time of the exit conference with the Administrator, Regional Director, Regional Maintenance Director and the Environmental Services Director on August 5, 2025, at 1:00 PM, confirmed the portable air conditioner was not vented to the outside.	K 0521	weeks, then monthly for two months. Results of audits will be reviewed at the Quarterly Quality Assurance and Improvement Committee Meeting over the duration of the audit process. Based on the results of the audits, a decision will be made regarding the need for continued submission and reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
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NAME OF PROVIDER OR SUPPLIER: AVENTURA AT PEMBROOKE STATE LICENSE NUMBER: 230602	STREET ADDRESS, CITY, STATE, ZIP CODE: 1130 WEST CHESTER PIKE WESTTOWN, PA 19382
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K 0911 SS=E		K 0911		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: AVENTURA AT PEMBROOKE STATE LICENSE NUMBER: 230602		STREET ADDRESS, CITY, STATE, ZIP CODE: 1130 WEST CHESTER PIKE WESTTOWN, PA 19382		
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K 0911 SS=E	Continued from page 20 NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0911	0911 The facility failed to maintain components of the electrical system, on one of four floors. No residents were affected. All residents have the potential to be affected. The 2nd floor Room 224, a receptacle near the A-bed was repaired and a cover was installed as required. 2nd floor Room 226, the reading light over the A-bed had non-terminated, exposed wiring hanging from the underside of the cover. An audit was completed by the Maintenance Director to ensure that all receptacles are installed as required and that all lights are installed as required. Director of Maintenance and maintenance staff were educated by the Administrator on the requirement. Also, maintenance director and maintenance staff were educated on requirement to audit the receptacles when installed. They were also educated that bedside lights must be inspected frequently for physical integrity.	Completion Date: 09/12/2025 Status: APPROVED Date: 08/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
NAME OF PROVIDER OR SUPPLIER: AVENTURA AT PEMBROOKE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1130 WEST CHESTER PIKE WESTTOWN, PA 19382		
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K 0911 SS=E	Continued from page 21	K 0911	<p>Education of floor staff (Certified nursing assistants professional nurses housekeepers) was initiated to report any damaged receptacles and over head lights to maintenance for repair.</p> <p>The Maintenance Director/Designee will conduct one weekly audit of random receptables for four weeks, then monthly for two months and then quarterly thereafter. In addition, auditing will occur for any newly installed receptacles and during room deep cleaning.</p> <p>The Maintenance Director/Designee will conduct one weekly audit for over head lamps for four weeks and then monthly for two months. Additionally, over head lamps will be audited when a repair or replacement is put in place.</p> <p>Results of audits will be reviewed at the Quarterly Quality Assurance and Improvement Committee Meeting over the duration of the audit process. Based on the results of the audits, a decision will be made regarding the need for continued submission and reporting.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
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K 0911 SS=E	Continued from page 22 Based on observation and interview, it was determined the facility failed to maintain components of the electrical system, on one of four floors within the component. Findings include: 1. Observation on August 5, 2025, between 11:20 AM and 11:25 AM, revealed the following electrical system deficiencies: a. 11:20 AM, 2nd floor Room 224, a receptacle near the A-bed was missing a cover; b. 11:25 AM, 2nd floor Room 226, the reading light over the A-bed had non-terminated, exposed wiring hanging from the underside of the cover. Interview at the time of the exit conference with the Administrator, Regional Director, Regional Maintenance Director and the Environmental Services Director on August 5, 2025, at 1:00 PM, confirmed the electrical system deficiencies.	K 0911		
K 0920 SS=E		K 0920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025	
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K 0920 SS=E	Continued from page 23 NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 0920	The facility failed to monitor for the unauthorized use of surge protectors and extension cords, on two of four floors. No residents were affected. All residents have the potential to be affected. The extension cord in Room 204 at B-bed on 2nd floor was removed to meet the requirement. The surge protector in Room 214 A-bed on 2nd floor was removed to meet the requirement. The extension cord in Room 104 at A-bed on 1st floor was removed to meet the requirement. An audit was completed by the Maintenance Director to ensure that no unauthorized surge protectors or extension cords are in use. Director of Maintenance and maintenance staff were educated by the Administrator on the requirement. The Maintenance Director/Designee will conduct one weekly audit to ensure compliance with unauthorized use of surge protector and extension cords for 4 weeks an	Completion Date: 09/12/2025 Status: APPROVED Date: 08/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025
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K 0920 SS=E	Continued from page 24	K 0920	than monthly thereafter. The audits will include new residents decorated areas and new equipment. Results of audits will be reviewed at the Quarterly Quality Assurance and Improvement Committee Meeting over the duration of the audit process. Based on the results of the audits, a decision will be made regarding the need for continued submission and reporting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395166	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/05/2025	
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K 0920 SS=E	Continued from page 25 Based on observation and interview, it was determined the facility failed to monitor for the unauthorized use of surge protectors and extension cords, on two of four floors within the component. Findings include: 1. Observation on August 5, 2025, between 11:34 AM and 12:03 PM, revealed the following unauthorized power sources: a. 11:34 AM, 2nd floor Room 204, an extension cord was powering a phone charger, at B-bed; b. 11:38 AM, 2nd floor Room 214, various medical devices, near A- bed, were being powered by a surge protector; c. 12:03 PM, 1st floor Room 104, an extension cord was powering a phone charger, at A-bed. Interview at the time of the exit conference with the Administrator, Regional Director, Regional Maintenance Director and the Environmental Services Director on August 5, 2025, at 1:00 PM, confirmed the surge protector and extension cords were in use, at the time of the survey.	K 0920		



Certified End Page

AVENTURA AT PEMBROOKE

STATE LICENSE NUMBER: 230602

SURVEY EXIT DATE: 08/05/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

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